Funding and Evaluating Primary Care Facilitation Programs

September 28, 2012

Janice Genevro, AHRQ
Lyndee Knox, LA Net
Submitting a Question to Q&A

- In the Q&A panel, please click on the dropdown menu arrow.
- A dropdown list of the panelists and an All Panelists selection will appear.

- **Select “All Panelists”**
  - Then type in your question in the field below the dropdown menu.
  - Hit “Send.”
  - The question will then be sent to all panelists.

Type in question

Hit “Send”
Introduction

Janice Genevro, AHRQ

For more information please visit:
http://www.pcmh.ahrq.gov
Acknowledgments

- This work is supported by the Agency for Healthcare Research and Quality (Contract No. HHSA290200900019I)

- Project team included:
  - AHRQ – David Meyers, Janice Genevro
  - LA Net – Lyndee Knox, Nadia Ramos
Lyndee Knox, PhD
Chief Executive Officer
L.A. Net, A Community Health Resource Network
Today’s Topics

- Voices from the Field
  - A health plan-based facilitation program
  - Facilitation in pediatric settings
- Budgets and Funding Sources
- Evaluating Facilitation Programs
- Future Directions
Voice from the Field

Hunter Gatewood, MSW
Director of Health Improvement
San Francisco Health Plan
Why San Francisco Health Plan Invests Our Resources in Practice Coaching

Hunter Gatewood,
Director of Health Improvement
San Francisco Health Plan
Who We Are, Who We Serve

- Medicaid managed care plan, in 15th year
- 73,000+ insured
  - Medi-Cal, Healthy Families, Healthy Kids, Healthy Workers
- 50,000+ Healthy San Francisco
  - [http://www.healthysanfrancisco.org](http://www.healthysanfrancisco.org)

Our goals

- Universal Coverage
- Quality Care and Access
- Exemplary Service
- Financial Viability for safety net
SFHP Provider Network

- 450 primary care providers
  - 28 clinics plus small practices
- 7 medical groups
- 2,000 specialists
- 100 mid-levels
- 6 hospitals, 9 campuses
- 200 pharmacies
- 200 vision providers
How We Influence Clinical Quality and Care Experience

- Pay for Performance
- Quality improvement (QI) learning and action projects
- Leadership development in clinics
- Care incentives for patients (plan members)
- Ongoing measurement and monitoring

http://www.sfhp.org/providers/quality_improvement/
Advancing Excellence in Health Care

Practice Coaching Across Programs

2010  Part of year-long collaborative

2011  Main support on a QI project, part of a clinics leadership course

2011 – 2012  Tailored to site’s request

2013 – 2015  Coaching program for 28 clinics
Why Practice Coaching?
Coaching Helps Spread of Key Changes

The World of Changes

Collaboratives

Hardwiring (Mandates)

Policy and Procedure

The march of time

Excitement and energy for change

Autonomy to Experiment

# of Options:

Innovators
Early Adopters
Early Majority
Late Majority
Holdouts
Beware: Lonely Ringing Pay Phone Phenomenon

Change mechanics of improvement to standardize, avoid project chaos.
2010
Coaching as Part of Learning Collaborative

- 4 clinics: Appointment Access, with Mark Murray
- 5 clinics: Improved Patient Communications, with Institute for Healthcare Communications
Results: Delay Reduction

TNAA Average by Clinic
# Clinics Cut Appointment Wait Time WHILE Taking More Patients

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Panel Size, April 2010</th>
<th>Panel Size, Dec 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinatown</td>
<td>3,706</td>
<td>4,021</td>
</tr>
<tr>
<td>Lyon-Martin Health Services</td>
<td>2,081</td>
<td>2,535</td>
</tr>
<tr>
<td>Maxine Hall</td>
<td>2,975</td>
<td>3,211</td>
</tr>
<tr>
<td>Southeast</td>
<td>3,001</td>
<td>3,100</td>
</tr>
</tbody>
</table>
## Communication Improvement Results, CAHPS visit survey

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>At 10 months</th>
<th>Absolute Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor knows important medical history</td>
<td>90.3%</td>
<td>91.9%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Doctor explanations easy to understand</td>
<td>94.8%</td>
<td>95.0%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Doctor shows respect</td>
<td>96.6%</td>
<td>96.9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Office Staff (composite)</td>
<td>94.1%</td>
<td>95.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Rating of provider</strong></td>
<td>86.1%</td>
<td>89.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Patient recommends clinic</td>
<td>89.7%</td>
<td>92.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Clerks and receptionists respectful</td>
<td>96.0%</td>
<td>96.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Clerks and receptionists helpful</td>
<td>92.3%</td>
<td>94.8%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
2011 Coaching for QI project as part of leadership development course

- 19 clinics, 2 clinic-network leadership teams
- 8 didactic sessions on leadership and management team development
- QI project, with a practice coach
  - EHR readiness
  - Appointment access or visit flow efficiency
  - Patient-centered communication
  - Behavioral health integration
Table 3: Results of Coach Evaluation

<table>
<thead>
<tr>
<th>Our QCS coach…</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neither (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>…helped our team apply the content provided at the 8 SFQCS learning sessions.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>7</td>
<td>4.10</td>
</tr>
<tr>
<td>…encouraged our team to test changes that we may not have done on our own.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>7</td>
<td>4.10</td>
</tr>
<tr>
<td>…helped extend the perspective of our team by providing outside experiences and sharing information from other clinic settings.</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>4.29</td>
</tr>
<tr>
<td>…helped us build a better and more effective team.</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>3.76</td>
</tr>
<tr>
<td>…was committed to our team’s success.</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>12</td>
<td>4.43</td>
</tr>
<tr>
<td>…bonded with our team through his/her motivation and encouragement.</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>4.15</td>
</tr>
<tr>
<td>…empowered our team by setting the stage and then giving us permission to do things on our own.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>8</td>
<td>4.20</td>
</tr>
<tr>
<td>…was a valuable resource because of his/her knowledge and expertise in the specific strategy we chose to work on.</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>11</td>
<td>4.24</td>
</tr>
<tr>
<td>…helped hold our team accountable to SFQCS deliverables.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>10</td>
<td>4.43</td>
</tr>
<tr>
<td>…was integral to the successful execution of our SFQCS QI project.</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>4.10</td>
</tr>
</tbody>
</table>
“Prior to QCS, we were not collecting or monitoring data in a standardized way. Our project and the training we received, and our QCS coach, dramatically enhanced our organization’s capacity to collect, analyze, monitor and respond to our data.”
2011 – 2012: Coaching by invitation, part of pay for performance
The Coaches

- **SFHP staff coaches (in-kind)**
  - Two IHI Improvement Advisor graduates
  - One IHI Practice Coaching Program student
  - One Project Management Professional

- **Contract coaches (grant-funded)**
  - One second-career PCP
  - One EHR implementation consultant
  - One (more) IHI Improvement Advisor

- **Educations (across all coaches)**
  - OT, MSW, MPH, MBA, RN/MD
Funding: Work with What You Have, and Build

- **Grants**

- **Coverage program funds**
  - SF Health Plan (Medicaid managed care)
  - Healthy San Francisco (access program)

- **In-kind salary support**
  - If you can commit to training and resources, QI staff will do this in addition to regular workload: fun, challenging, rewarding
Coaching program to reach 28 clinics

- Coaches: SFHP and UCSF Center for Excellence in Primary Care
- Goal: 10 Building Blocks of High-Performing Primary Care
  - Bodenheimer et al.’s step-wise model, includes: data-driven improvement, team-based care, population management, access to care, care coordination
- Opportunity
  - Align PCMH-related content, delivery
  - Serve clinics at different starting points
  - Help clinics integrate lessons from past efforts
Lessons Learned by SFHP

- Yes, you can start small and build up
- **Roles! Expectations!** Scope coach role
  - QI process?
  - Project management?
  - Subject matter expertise?
  - NOT a staff resource to lead project for clinic
- Train coaches on role, they train sites
- Works with/without a collaborative
- Without a collaborative, need time and structure for didactic topic content
Hunter Gatewood,
Director of Health Improvement
hgatewood@sfhp.org
Facilitation in Pediatric Practices
Voice from the Field

Jeanne W. McAllister, BSN, MS, MHA
Director
Center for Medical Home Improvement
Crotched Mountain Foundation
Facilitation in the Pediatric, Family-Centered Medical Home

Jeanne W. McAllister, BSN, MS, MHA
Director, Center for Medical Home Improvement
http://www.medicalhomeimprovement.org
Co-Director, National Center for Health Care Transition
http://www.gottransition.org
Adjunct Assistant Professor Psychiatry & Pediatrics
Geisel School of Medicine at Dartmouth
1997 CMHI - Began Facilitation in Pediatrics – At that time clarification was needed with every aspect including how to have a team meeting…

- What is a medical home?
  - What do we do? How do we measure it?

- A team of clinician, care coordinator and parent?
  - What is a parent partner? How do we choose/engage and use them?
  - What is a care coordinator? How do I find one? How do we pay for them?

- What do you mean by Children/Youth with Special Health Care Needs (CSHCN)?
  - What conditions are "included"
  - How do you rank a child's needs using complexity
  - What is a registry?
  - What is a care plan?
Pediatric Context/History/Today: MCHB Priorities/National Centers/$ Support
http://www.communitybasedservices.org/mchb-national-centers

1. Families as Partners - Family Voices (national and state)
   - Center for Cultural Effectiveness - Georgetown

2. Medical Home –
   - AAP National Center for Medical Home Implementation
   - MH Learning Collaboratives
   - State implementation grants

3. Insurance - Catalyst Center

4. Screening (Early and Continuously for SHCNs)

5. Ease of Access to Community-based services

6. Health Care Transition – GotTransition? All aspects of adult life, including adult health care, work, and independence.
Pediatrics – Unique?
Most Proud of?

COMMUNITY/FAMILY & FAMILY SUCCESS
Build & Learn from Previous Work

- **TAPPP**
  - **T**eamwork (leadership; families)
  - **A**ccess options/communication
  - **P**opulation (CSHCN/All children)
  - **P**lanned coordinated care
  - **P**atient and Family-Centered Care

Mindset – Mission orientation/culture practice team best people in world

Patient & Family Centered Care

TO

WITH

Help families succeed in their community; Help parent partners outside of team meetings; be a boundary spanner for team

FOR
Emphasis on partnerships “Nothing for us, without us”

Continuum of ways to engage patients & families, as:

- **Providers of Feedback**
  - Suggestion box
  - Q&A Poker Chips
  - Surveys

- **Experience of Care/ Tutors**
  - Diaries
  - Focus Groups
  - Practice walk thru

- **Teachers/Story**
  - About their family
  - Topical/review panel experts
  - Workshop speakers

- **Partners for Improvement**
  - Practice team/ redesign partners
  - Advisory/Boards
Facilitation in pediatrics 2012
Keep growing, deepening the work

- Engaged in ongoing, continuous effort to make things better (AKA QI vs. Transformation)
- Engage families/youth 10 ways > 10 times
- Coordinated care; care plans; with mutual goal setting; linkages to community professionals and their “care plans”
  - Engage community neighborhood/connections
- Health Care Transitions (with an across the lifespan attitude)
  - Providers/settings
  - Process of a) preparation b) planning and c) implementation
    Six Core Elements of Health Care Transition www.gottransition.org
  - Expectations/communications Pediatric and Adult Practices
- Funding for Facilitation in Pediatric settings
  - USMCHB/Title V/Chapters; Hospital networks (Rainbow Babies); CHIPRA
## Three Maxims - Blended Principles to Remember

<table>
<thead>
<tr>
<th>Maxim</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) “The needs of the patient (family) come first.”</td>
<td>The idea that designs of (practice) habit or convenience are subordinate to designs that serve the patient (child, youth, family)</td>
</tr>
<tr>
<td>(2) “Nothing about me without me.” <em>(Nothing for us without us)</em></td>
<td>Levels of transparency and participation uncharacteristic of most health care systems. <em>(partnership)</em></td>
</tr>
<tr>
<td>(3) “Every patient is the only patient.”</td>
<td>We are “guest” in the patient’s (families) life; expresses confidence in the feasibility and desirability of customization of care to the level of the individual (memory).</td>
</tr>
</tbody>
</table>
Funding Your Practice Facilitation Program

Resources in the How-To Manual
How-To Manual

Expert Contributors

Carolyn Allshouse  Ann Lefebvre
Cheryl Aspy  Clare Liddy
Thomas Bodenheimer  Jeanne McAllister
Bonni Brownlee  Marly McMillen
Caroline Carter  Gail McNutt
Katie Coleman  James Mold
Darren DeWalt  Regina Neal
Perry Dickinson  Amanda Parsons
Elizabeth Foley  Joan Pernice
Brenda Fraser  Diane Powers
Allyson Gottsman  Mary Ruhe
Joanne Gutowsky  Constance Sixta
William Hogg  Jenney Samuelson
Craig Jones  Lisa Watkins
Chapter 3. Funding Your Practice Facilitation Program (Pages 23-32)

- Creating a Business Plan for your program
- Develop a plan for funding your program
- Potential funders for PF programs
- Typical program costs and budgets
- Market your program to funders
- Practical resources
## Funding Sources & Strategies

<table>
<thead>
<tr>
<th>Source</th>
<th>Type(s)</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal</strong></td>
<td>Longer-term; programmatic; Project-focused</td>
<td>• AHRQ grants and task orders (research focus only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• AHRQ’s Primary Care Extension program (if funded)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HRSA, Bureau of Primary Care Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMS, Center for Medicare and Medicaid Innovation</td>
</tr>
<tr>
<td><strong>State/county health departments</strong></td>
<td>Programmatic; Project-focused</td>
<td>• Vermont Health Department’s Blueprint for Health</td>
</tr>
<tr>
<td><strong>Single payers and multipayer groups</strong></td>
<td>Programmatic; Project-focused</td>
<td>• L.A. Care NCQA PCMH Coaching Initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pennsylvania’s multipayer collaborative</td>
</tr>
<tr>
<td><strong>Philanthropic</strong></td>
<td>Project-focused</td>
<td>• Commonwealth Fund’s Safety Net Initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RWJF’s Improving Performance in Practice (IPIP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• California HealthCare Foundation</td>
</tr>
<tr>
<td><strong>Provider organizations and associations</strong></td>
<td>Programmatic; Project-focused</td>
<td>• Primary care associations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• IPA in Northern California</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Brookings ACO Learning Network</td>
</tr>
<tr>
<td><strong>Business community</strong></td>
<td>Programmatic; Project-focused</td>
<td>• Large employers such as IBM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient-Centered Primary Care Collaborative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Business coalitions</td>
</tr>
<tr>
<td><strong>Advocacy organizations</strong></td>
<td>Project-focused</td>
<td>• Community Health Councils of L.A. partnership w/ LA Net’s PF program to improve diabetes care</td>
</tr>
</tbody>
</table>
Funding Practice Facilitation Programs

Michael Parchman, MD, MPH
Director
MacColl Center for Health Care Innovation
at the Group Health Research Institute
Cost of Practice Facilitation and Some Ideas for Funding

Michael Parchman
Director, MacColl Center
Group Health
Background: ABC Study

- Randomize 40 small independent primary care offices/clinics
- Use Practice Facilitation to improve ABCs for diabetes by implementing the Chronic Care Model
  - A1c
  - Blood Pressure
  - Cholesterol
Practice Facilitation Role in ABC Study

- Welcome Visit
- Baselines Assessment
  - Staff survey
  - Patient Survey
  - Chart Audit
- Practice Report: start the conversation
- “Toolbox” of ideas for improvement
- At least 6 “improvement team meetings” with PF over 12 months
Cost of Practice Facilitation Analysis

- Calculated direct variable costs of facilitation: Facilitator time, travel and food
- Cost estimates do not include the cost of facilitator training, or the fixed costs of office rent, utilities, information technology etc. which are likely to vary by geographic location
- Assumptions about Facilitator Salary: hourly wage of $30 (~$60,000 per year in wages and benefits)
Practice Facilitation Activities

- Orientation and Planning
- Practice Evaluation
- Active Facilitation
- Monitoring, Assessment, Feedback
Cost of Practice Facilitation in ABC Study

- Total annual average facilitation cost per clinic was $10,250 (range $8,047 to $15,682).

- Approximately 50% of total cost is attributable to practice assessment and start-up activities, with another 31% attributable to active facilitation visits.

- Sensitivity analysis suggests that the total average costs of a 24-visit protocol would only increase cost per clinic to $16,284.
<table>
<thead>
<tr>
<th>PF Activity</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitation Orientation</td>
<td>$409</td>
<td>$374</td>
<td>$291 to $627</td>
</tr>
<tr>
<td>Practice Evaluation</td>
<td>$2,995</td>
<td>$2,992</td>
<td>$2,602 to $3,577</td>
</tr>
<tr>
<td>Creating and Providing Baseline Report</td>
<td>$1,220</td>
<td>$1,133</td>
<td>$968 to $2,099</td>
</tr>
<tr>
<td>Active Facilitation</td>
<td>$1,414</td>
<td>$1,315</td>
<td>$1,225 to $1,962</td>
</tr>
<tr>
<td>Monitor/Assess/ Feedback</td>
<td>$452</td>
<td>$447</td>
<td>$318 to $614</td>
</tr>
<tr>
<td>Travel Costs/Food</td>
<td>$924</td>
<td>$765</td>
<td>$418 to $2,447</td>
</tr>
</tbody>
</table>
Caveats

- Only variable costs, not fixed costs
- Does not include facilitator training
- Only the first year of a new program so practice evaluation costs will go down in future years
What would a Practice Facilitation Program look like in an Accountable Care Organization (ACO)?

- Assume organization with 60 primary care practices, Practice Facilitation cost at $10,000 to $13,000 per practice per year, 1 Practice Facilitation per 10 practices.

- Total direct variable costs over the first year would be approximately $600,000 to $780,000.

- Assume overhead/indirect cost rate of 40%, the total costs would be $1,000,000 to $1,300,000 in the first year of the program.

- Much of cost of Practice Facilitation is devoted to start-up and practice assessment. As a result, the costs of facilitation activities for an ACO in subsequent years are likely to decrease.
The ROI for Practice Facilitation

- Medicare ProPAC reported in 2009 (during the study period) that acute care hospital cost per discharge on average ranged from $5,800 to $6,400.

- Using the lower of these estimates, the breakeven case for returning direct variable cost of Practice Facilitation activities from a delivery system perspective is that Practice Facilitation activities would pay for itself if a practice could reduce the number of future hospitalization or readmissions by 2 per year.
How Develop Sustainable Funding for a Practice Facilitation Program

- Be creative
- Entrepreneur
- Think “market” “message” “networking”
- Identify needs of clients and meet those needs
Develop Your “Elevator Speech”

- Delivery of primary care is a team sport
- Every team Needs a coach
Identify Potential Customers

- Health Plans
- Professional Organizations
- Newly formed ACOs
- Hospitals (e.g. think reducing 30 day readmissions)
- State Medicaid Programs
- Health Care Control Networks (comprised of Federally Qualified Health Centers)
Health Plans: Competitive Advantage?

Health Plan → Products

- Delivery System/Provider Organizations
- Optional PF program: Improve Care Management & Quality?

Purchasers/Employers
Practice Facilitation as a Component of a Larger Program: Control Costs/Improve Quality

- Lessons from Medicare’s Demonstration Projects on Disease Management & Care Coordination
- 34 programs “…had little or no effect…”
- Of the 18 programs with fees at risk:
  - 2 of 18 programs reduced total Medicare spending
  - 1 program increased spending
  - 15 “had no discernable effect”

Congressional Budget Office Issue Brief, January 2012
Disease Manage/Care Management

- Health plans think they know how
- The gap is huge
- Employers and purchasers are demanding changes
Questions at end...
Chapter 8. Evaluating the Quality and Outcomes of Your Facilitation Program (Pages 87-96)

- **Evaluation**
  - Why evaluate?
  - What is the “sweet spot?” – feasibility/rigor balance
  - Selecting a study design
  - Outcomes to consider
  - Sources of data

- **Research – Generating Generalizable Knowledge**
  - What to consider
  - When to participate
Findings from the 2012 Systematic Review of Practice Facilitation
Perspectives on Evaluating Practice Facilitation Programs

Bruce Baskerville, PhD
Senior Scientist & Associate Research Professor
Propel Center for Population Health Impact
University of Waterloo
A Systematic Review and Meta-analysis of Practice Facilitation Within Primary Care Settings

N. Bruce Baskerville, B.A.(Hons.),M.H.A.,Ph.D.¹

¹Propel Centre for Population Health Impact, University of Waterloo

September 28, 2012

Practice Facilitation Webinar, Agency for Healthcare Research and Quality

Introduction

- The evidence-practice gap
- Barriers to professional behavior change:
  - Professional context
  - Organizational context
  - Environmental context
- Systematic reviews have excluded practice facilitation
- Practice facilitation is multifaceted and narrative reviews (Nagykaldi et al. 2005) indicate impact
Research Questions

- What is the overall effect size of practice facilitation for the implementation of guidelines?
- What factors moderate that impact?
Methods – Data Collection

- **Inclusion criteria** - Controlled trials or evaluations of practice facilitation in primary care settings published from 1966 to December 2010 in English language journals.

- **Primary outcome** - change in evidence-based practice behavior calculated as a standardized mean difference (SMD).

- **Quality assessment** - Modified 12 point version of the PEDro scale, quality score range 0 to 12.

- **Studies independently rated by three reviewers** - inter-rater reliability very good $K = .78$ (95% CI 0.73-0.84).

---

1 Bhogal, S. et al. The PEDro scale provides a more comprehensive measure of methodological quality than the Jadad scale in stroke rehabilitation literature. Journal of Clinical Epidemiology 2005; 58: 668-673.
Flowchart of Identification of Relevant Studies

Reasons for exclusion:
- 76% were non-randomized trials
- 95% did not blind outcome assessments
- 100% did not report allocation concealment
- 7 of 9 randomized trials were excluded due to unmatched groups at baseline
Results - Study and Intervention Characteristics (n=23)

- 20 studies were randomized controlled trials.
- 52% US-based studies.
- 83% of studies reported a form of preventive service as the primary outcome measure.
- 44% of studies described qualifications of facilitator as registered nurse or masters educated.
- Audit and feedback was a component of 97% of studies, 91% employed consensus building, and 39% used a reminder system.
- 74% reported that the practice facilitator tailored the intervention to the needs of the practice.
1,398 participating practices - 701 allocated to control and 697 to practice facilitation

Standardized Mean Difference (SMD) = 0.56 (95% CI 0.43-0.68), z=8.76, p < .00001

Heterogeneity non-significant, $X^2(1,N=22)=27.55$, $p=.19$, $I^2 = .20$
Results – Number of Practices per Facilitator

Ratio of Practices per Facilitator and Effect Size (n=21)

\[ B = -.02, \ p = .004 \]
Results – Intensity of Facilitation

Intensity of Intervention and Effect Size (n=23)

\[ B = 0.008, \ p = 0.03 \]
Results – Tailoring to Practice Context

Tailoring to Practice Context and Effect Size (n=23)

Point Estimate

Tailored

Not Tailored

$p = .05$
Key Take Away Messages

- Primary care practices are 2.76 (95% CI 2.18 - 3.43) times more likely to adopt evidence-based guidelines through practice facilitation
  - Practice facilitation works - despite the professional, organizational and broader environmental challenges of getting evidence into practice.

- Variation in the process of implementation significantly influenced effects:
  - Number of primary care practices assigned to each facilitator;
  - The intensity of the intervention in terms of contacts and hours per contact; and
  - Tailoring to the needs of the practice.

- Majority of studies focused on adoption of preventive care guidelines
  - Can practice facilitation work for chronic illness care management?

- Larger scale, collaborative, practice-based evaluation research is needed
  - Sustainability and costs-benefit to the health system.
Questions at end...

Bruce Baskerville, PhD
Senior Scientist
Propel Centre for Population Health Impact
University of Waterloo
Email: nbbaskerville@uwaterloo.ca
Telephone: (519) 888-4567 ext. 35236
Practical Considerations for Evaluating a Practice Facilitation Program
Perspectives on Evaluating Your Practice Facilitation Program

James W. Mold, MD, MPH
Director of Oklahoma Physicians Resource/Research Network (OKPRN)
University of Oklahoma
Disclaimer

- My training, interest, and expertise are not in the area of program evaluation, so take my suggestions with the appropriate amount of salt.

- We have never considered our series of implementation projects as a “facilitation program,” so it is difficult for me to think about “program evaluation,” but since I have been asked to reflect on this, I guess there are at least 3 levels of evaluation involved:
  - Ongoing evaluation of the effectiveness of individual facilitators
  - Evaluation of the process and outcomes of specific initiatives
  - Ongoing evaluation of the effectiveness/cost effectiveness across a series of initiatives
Evaluation of Individual Facilitators

Most of the time the facilitators are acting independently, so it is more difficult to evaluate their activities. We use 5 different sources of information:

- Weekly individual and group meetings to review progress and challenges
- Visit notes, which include required quantitative process information in addition to qualitative information
- Feedback from the practices, both informal and formal
- Direct observation (limited)
- Performance data from the practices
- Annual evaluation
Typical Facilitator Schedule

- 8 practices per facilitator per 6 month project cycle
- ½ day per practice per week so 4 days per week in practices
- 1 day per week in the Department
  - 30 minute individual debriefing session with supervisor to discuss progress in each practice and specific challenges
  - 1 hour group meeting to review each ongoing project (typically 5-6), with an emphasis on logistics (enrollment, milestones, challenges, opportunities, etc.)
  - 1 hour training
  - 6 hours to catch up on paperwork, research for the practices, scheduling, etc.
Visit Notes

Process measures

- Time preparing for the visit
- Time in practice - (We believe that it is important for the facilitators to spend a full half-day in each practice every week, even if they have nothing specific to do.)
  - Broken down into specific types of activities
- Perception of progress made toward meeting objectives
Feedback from Practices

- Encouraged to contact supervisor at any time
- One-page evaluation form to be completed periodically
  - Rating scales
  - Qualitative assessment of facilitator performance
- Sporadic queries by supervisors when visiting practices or with clinicians for other reasons
Evaluation of Individual Initiatives

- Performance improvement across all practices
  - Typically see between 30% and 400% improvement in proportions of patients/visits meeting expectations

- Performance improvement between practices within facilitators

- Improvement in practice change capacity (the component of Solberg’s QI for which facilitation is our major intervention)
  - Priority for change: Performance evaluation/feedback, academic detailing, facilitation, learning collaboratives
  - **Change capacity: Facilitation**
  - Care process content: Academic detailing, facilitation, learning collaboratives
Evaluation of a Series of Initiatives

- Based upon goals and objectives of the organization

- **Process**
  - Multiple domains possible
  - Facilitator job satisfaction

- **Outcomes**
  - Requires some sort of comparison group so cRCT, step-wedge design, time lag, etc.

- **Cost** – Our cost is $5,000 - $7,500 per practice per year, but this could be reduced with less travel and existing relationships between facilitators and practices.
Ideas on Future Directions for Practice Facilitation
Effective Implementation of Innovations in Primary Care

- Literature and Exemplar Methods
- Academic Detailing
- Facilitation
- IT Support
- Practice Enhancement Assistant
- Performance Feedback
- Local Learning Collaboratives
- Assistant Literature and Exemplar Methods
Challenges and Revelations

- Success depends heavily upon the strength of relationships between practice and facilitator
- Cost can be reduced by embedding facilitators within communities of practices
  - Longitudinal relationships
  - Less travel time/cost
- That’s Cooperative Extension!
An Extension System for Primary Care

- Message reached the right people (law of the few)
  - Kevin Grumbach, Art Kaufman, David Meyers, Bob Phillips
- Concept of PC extension caught on (sticky idea)
  - HIT Regional Extension Centers
- Affordable Care Act (context was right)
  - Section 5405: Primary Care Extension Program
  - Authorized but funding not appropriated
  - Assigned to AHRQ
- AHRQ RFA: IMPaCT
  - 4 awards (9/11 – 8/13): NC, PA, NM, and OK
  - Dissemination to 12 additional states (3 each) so 16 states
  - National IMPaCT meeting in OKC Feb 2013
Primary Care Extension in Oklahoma

- A state hub: The Public Health Institute of OK
  - 501c3 organization established to improve the health of Oklahomans

- AHECs as Regional Coordinating Centers connecting CHIOs to academic resources
  - Will hire, deploy, and supervise facilitators who live and work within their own counties
  - Will arrange for academic detailing when appropriate/requested

- Certified non-profits developed from existing coalitions in each county or county cluster called County Health Improvement Organizations (CHIOs) with primary care involvement (BOD and Advisory Committee)
  - Mission: Improve the health of citizens of county
Funding and Programs

- **Sustainable funding**
  - Health insurance companies through Minimum Risk Ratio
  - Tobacco Settlement Endowment Trust
  - Practice membership fees

- **Project-specific funding**
  - CDC, HRSA, CMS, AHRQ, NIH, TSET, foundations, etc. etc.

- **Programs**
  - QI in primary care practices (e.g. HIT, HIE, PCMH)
  - Shared resources for practices (e.g. care managers, community health workers, mental health clinicians)
  - Community-based health improvement projects
Questions & Answers

Please submit your questions through the Q&A panel on the right hand side of your screen
Thank You & Next Steps

- Please respond to the survey *immediately* following this webinar
  - Please give us your ideas for shaping the future of Practice Facilitation

- Please join AHRQ’s PF listserv by emailing PCPF-request@LIST.AHRQ.GOV

- Visit [http://www.pcmh.ahrq.gov](http://www.pcmh.ahrq.gov)
  - Note the Practice Facilitation webpage